EXHIBIT 29

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

MARISSA COLLINS, on her own behalf, and on behalf of all others similarly situated, and JAMES BURNETT, on behalf of his son, and on behalf of all others similarly situated, and KARYN SANCHEZ, on behalf of her minor son and all others similarly situated,	)	
Plaintiffs,	)	
Vs.	)	Case No. 2:20-cv-1969
ANTHEM, INC. And ANTHEM UM SERVICES, INC.,	)	
Defendants.	)	

VIDEOTAPED DEPOSITION OF
MARC FISHMAN, M.D.

JOB NO: 5361537
TAKEN: August 25, 2022
TIME: 9:30 a.m.
STENOGRAPHICALLY REPORTED BY:
Brandi Bigalke, RPR, RSA, CSR NO. 084-4870

REMOTE APPEARANCES:

On Behalf of the Plaintiffs:
ZUCKERMAN SPAEDER LLP
BY: CAROLINE REYNOLDS, ESQ.
SAMANTHA M. GERENCIR, ESQ.
101 East Kennedy Boulevard, Suite 1200
Tampa, Florida 33602-5838
EMAIL: Creynolds@zuckerman.com

On Behalf of the Defendants:
REED SMITH LLP
BY: ROBERT DEEGAN, ESQ.
JENNIFER B. COOK, ESQ.
10 South Wacker Drive, 40th Floor
Chicago, Illinois 60606
EMAIL: Rdeegan@reedsmith.com

ALSO PRESENT:

John Worobij, Gravitystack

Kevin Duncan, Video Operator

would say that there are documents that reflect a predominant consensus, yes.

Q. By predominant, can you elaborate on that?

A. That most people with knowledge of the field would concur that they articulate the current consensus for what constitutes the generally accepted standard of care.

Q. Okay. And is it in your experience -- can you identify the documents or the items that you believe fall within that category of predominant?

MS. REYNOLDS: Object to form.

THE WITNESS: Yeah. They might include clinical guidelines. For example, a professional association through a process of expert consensus might publish a clinical guideline.

So, for example, the American Society of Addiction Medicine published a clinical guideline for the treatment of opioid use disorder. I know about that one because I was on the advisory committee, and so that -- of how a predominant consensus is articulated. And I would say that that represents elements of the generally

accepted standard of care.

And as I said in my report, I think the American Society of Addiction Medicine, ASAM Criteria is another such document that articulates and reflects the generally accepted standard of care.

BY MR. DEEGAN:

Q. And aside --

A. Those are two examples.

Q. All right. Two examples.

Do you have other examples?

A. Well, those are two starting places.

Do you want me to try to find other ones?

Q. Just asking for examples.

I'm trying to define, you know, figure out where the boundaries of -- you know, you opine a lot about generally accepted standard of care, and that topic has come up couple of times this morning, and I'm trying to define the boundaries of that.

A. Yeah. I think another place that one would look for articulation of the generally accepted standard of care is in local regulatory guidelines which help define the standard of care.

BY MR. DEEGAN:

Q. Okay. And would you agree that that's what your report says, correct?

A. Yes.

Q. And did you look at any individual files to determine whether -- to test that conclusion?

A. I did not. I was not asked to opine about individual cases. My opinion was that as written, guidelines will result in that restrictiveness.

Q. And how are you able to base that with respect to Anthem's population, the population that Anthem is making determinations with in the absence of individual files?

MS. REYNOLDS: Object to form.

THE WITNESS: I can only form an opinion about the guidelines themselves, which make very explicit statements about what is to be considered medically necessary and not. And so my opinion is about how the guidelines themselves shape that determination about medical necessity. And it's my opinion that that is overly restrictive.

I don't know about any one

treatment need decisions treatment placement decisions. So it's the first step. And a set of alternate guidelines that did that would be moving towards a good first step. I'm all for it. It's not enough, but it's a good start.

BY MR. DEEGAN:

Q. Okay. So just to clarify.

So actual organization, the way information is presented in level of care guidelines, is it your opinion that that organization -- organization itself is a component in the analysis of whether something is a generally accepted -- satisfies the generally accepted standards of care or not?

A. Yes. It should be multidimensional. It should be holistic. It should take into account these core concepts. If it's -- I don't want to wordsmith about it. If it's manned differently, if it's ordered differently, if it's delineated according to a different taxonomic rubric, that's also okay.

Q. I see.

What about placing emphasis on one factor versus another?

So, for example, does the ASAM

Q. -- ASAM suggests that you should be at a 3.1, there's no 3.1 in your area necessarily, rather than going to a 3.5 -- sorry, there's no dedicated 3.1 in your area, rather than being sent to a 3.5, it's your opinion that you can essentially, based on the individual circumstances and the individual services available to that individual, that person, you create your own 3.1?

A. Yeah. Or close enough. And this would be a risk-benefit analysis both for the individual patient and for the potential downside of 3.5 which is somewhat more restrictive and, you know, does that have some downside, it might depending on the upside.

And it's a balance. Would the supportive residential structure of that particular recovery house be structured and supportive enough for this patient to substitute for the equivalent residential component of the hoped-for available 3.1. Would the clinical staff of the 2.1 or 2.5 intensive outpatient that you're utilizing have enough integration with the staff of the recovery house to create a -- I don't want to go as far as to say seamless, but approaching in the integration of the two components, the

clinical component and the residential component that we would have hoped for in 3.1, could you make good enough with the shoestring and beeswax approach of putting together 2.1 or 2.5 and the recovery residence because those particular instances of that 2.1 and that recovery residence play well enough or integrate well enough together.

And so the burden is to demonstrate that it is equivalent enough to be sufficiently effective for that patient. If it works, that's great. The idea is, okay, you got to demonstrate that the default of rounding up is not necessary. But it's an alternative approach which works sometimes. I'm okay with that.

Q. All right.

A. But it does require -- it isn't automatic. It requires, you know, a thoughtful exercise of let's go through our paces and see if it's going to work, or let's round up.

Q. Okay. And just to be clear, but in terms of going through the paces, that means looking at the individual circumstances, the individual available services?

A. Yeah. That's right.

and of itself is indicative of an overemphasis on acuity?

MS. REYNOLDS: Object to form.

THE WITNESS: It to me is part of an overall impression given by these criteria that is cumulative. It includes the use of those words, but it also includes, as I mentioned before, a question {ph} that there's a certain requirement for direct medical service intensity.

That there needs to be -- this is described later on in another one of the alphabetical sections -- that there needs to be a certain amount of psychiatric severity.

What I'm describing or trying to describe or trying to articulate is to me a shift to higher severity and higher crisis status than I think is warranted as the pathway for admission to this level of care.

Not that there aren't other pathways. And so if a person needs certain pathways in these guidelines, then that's appropriate.

But again, my point is too much emphasis on the acute without enough consideration of what might be contributed by the chronic and

cumulative, that also puts people at risk of eminent harm.

BY MR. DEEGAN:

Q. Okay. And I think earlier -- well, actually, let's do this in two phases.

First, would you agree that under Subsection F1, right, there is actually two conditions that would allow an individual to satisfy F1; is that right?

MS. REYNOLDS: Object to form.

THE WITNESS: In F1 that there are two -- say that again, please.

BY MR. DEEGAN:

Q. Sure.

That F1 -- you can satisfy F1 by either the clause before the 'or' in F1 or the clause after the 'or' in F1.

A. Do you mean the distinction between substance use or mental health symptoms?

Q. Yes. Experiencing an acute crisis marked by intensification of substance use, or mental health symptoms that pose a serious risk of harm to self or others without 24-hour monitoring and support.

MS. REYNOLDS: Object to form.

different is that, or how do you see the difference between that and acute stress disorder?

A. Well, I think it's a nice illustration of a nonmedical intervention, but I don't think that it's that different.

Q. Okay. And then we see "safely and effectively initiate antagonist or agonist therapy."

Do you see that?

A. Yes. Not --

Q. Then there's the parentheticals, right, naltrexone and methadone?

A. But non-materially different, I agree.

Q. Okay. So again, I'm trying to draw -- the Sub Criteria 3 in F is essentially the same as Sub Criteria 3 in 5, Dimension 5 here for the 3.7, same level of care?

A. Yes. Not materially different. But for me the context is again the point of the context of the inappropriate characterization of the level of care as emphasizing direct medical service delivery, and that adds, in my view, to the cumulative impression of an over-restrictive emphasis on acuity and severity.

population, I don't think that by doing that that is providing more care than is necessary. I don't think that violates the standard of care.

It might be more expensive. I don't know it violates -- say necessarily does people harm.

Q. I see.

A. But I think that to set it as an inclusion criteria conveys the message of a requirement for severity asking the experienced clinician to say, well, that's a person that needs to be provided direct medical staff service at least weekly, and that conveys a picture of a certain level of severity that I don't think -- that I think is overly restrictive and overly acute for this level of care because I think that there are many, many patients appropriately treated in this level of care who would be monitored by the physician but whose direct service provision would be by nurses and nonmedical clinicians that the doctor or other member of the medical staff would be tracking their progress, but not necessarily directly hands-on at the level of week by week.

Might be, but wouldn't have to be

for all patients. And so that for me is -- sets a threshold that is inappropriate.

Q. I see.

So does this go to your impressionistic -- cumulative impression opinion that has come up a couple of times this afternoon?

A. It adds to it, yes.

MS. REYNOLDS: Form.

THE WITNESS: And by the way, it's also in residential treatment center without 24-hour nursing.

BY MR. DEEGAN:

Q. Okay. So I think we'll get to that example next.

So you have experience in managing 3.7 facilities, right?

A. Yes.

Q. Are there requirements with respect to how often a physician evaluates an individual?

A. No.

Q. So you're not even -- in your facilities you don't even -- it's not even a requirement to evaluate them at admission?

MS. REYNOLDS: Object to form.

THE WITNESS: Yes, at admission.

and we're just discussing the CG-BEH-04. And I think what we can do now, why don't we move on to --

MR. DEEGAN: John, if you could pull up page 26 of the report.

BY MR. DEEGAN:

Q. Okay. So we've pulled up page 26 of your report, the MCG Guidelines - deviations from generally accepted standards of care. And this section runs through the -- halfway through page 29. And then you have Subpart A, MCG Guidelines, and you list a number of bullet points.

Can you confirm that those are the four areas in which you believe the MCG deviate from generally accepted standards of care?

MS. REYNOLDS: Object to form.

BY MR. DEEGAN:

Q. Are you able to answer?

A. Oh, yes. My apologies. I thought you heard me.

Q. Okay. If you scroll to the next page, please.

All right. Here we have Subpart B, Inadequate attention to multidimensional assessment.

So I think we've talked variously today around different dimensions in or associated with ASAM, right?

A. Correct.

Q. And at -- level those dimensions -- include acute intoxication and/or withdrawal potential, biomedical conditions and complications, emotional, behavioral, or cognitive conditions and complications, readiness to change, relapsed continued use or continued problem potential, and recovery of living environment.

Does that accurately state the six dimensions in the ASAM?

A. Yes.

Q. And within those the ASAM also grades severity?

A. Yes.

Q. Okay. And is it your opinion that the MCG do not address the dimensions described by the ASAM Criteria?

A. Well, I think they address them in insufficient detail, and I think they -- by not providing some granularity and some illustrated examples, they don't provide what I think is sufficiently rich guidance to the user to fill out

that multidimensional assessment, which I think is necessary.

Another issue is I think that of the six dimensions, there is particularly insufficient attention paid to Dimension 3, or psychiatric psychological comorbidity as a pathway for the inclusion criteria for admission.

Q. Okay. So there are a number of points there.

So when you say a lack of richness for a user, I just want to be clear, is that true regardless of whether the user is a psychiatrist, an addiction medicine physician who is certified in addiction medicine, a physician who is board certified psychiatrist?

Does that change your opinion?

A. No. The issue is since we, as you and I have discussed, do want to allow for individualization and clinical judgment, and that so much interpretation is appropriately needed, illustrations and examples are very helpful to convey the details and the intention and the meaning.

So one of the things in the guidelines that we were previously reviewing today

is that they did have a variety of examples that were I thought very useful illustrations to the user. So that's a plus to them. It makes the -- longer to read, but it makes it richer, in my view. And the lack of richness takes away from what I think is a necessary emphasis on multidimensional assessment.

Q. But isn't multidimensional assessment going to be the background approach that a psychiatrist is going to take when making a level of care determination?

MS. REYNOLDS: Object to form.

THE WITNESS: Yes. I agree that psychiatrists will be trained in that approach. And for that reason, it would be useful to give them illustrations that give examples of what is meaned by this level of severity, that level of severity, what is a crisis, what is not a crisis.

We've talked a little bit about this today in the use of parentheticals to convey the nuance of what is meant by certain words that's helpful to understand their intent.

BY MR. DEEGAN:

Q. So is it your opinion that the physician reviewer is coming into the RTC level of

A. Yes. Yes. And this is better.
Q. Okay.
MR. DEEGAN: So let's go to on the left-hand side, John, would you go to the second page again.
BY MR. DEEGAN:
Q. I do want to talk about this bullet point very short-term crisis intervention and resource planning for further care at nonresidential level is unavailable or inappropriate.
And I think you have -- you take specific umbrage to this criteria?
A. Umbrage, yes.
Q. Is that fair to say?
A. Yes.
Q. On page 28 of your report?
A. Yes.
Q. But in the context of the described anecdotally as the Goldilocks factor, isn't this supportive of the idea that you're keeping a person in the least restrictive environment to be treated safely and effectively?
MS. REYNOLDS: Object to form.
THE WITNESS: I think it doesn't do

that. I think it reads like a let's do the least possible and let's find a short-term crisis intervention Band-Aid, Band-Aid is my words, it may be unfair coloration, but it expresses the impression given here as if that was equivalent to residential treatment.

And crisis intervention care tends to be, as I'm familiar with it, not that I know every instance of it, but to be three days for patients that you're trying to -- that might be temporarily suicidal, you're trying to keep out of the hospital to use a phychiatric analogy rather than an SUD analogy, but it's not equivalent to the effectiveness of residential care that attempts to provide a habilitative or rehabilitative treatment service. It's a keep them safe for the moment while we figure something out.

BY MR. DEEGAN:

Q. Well, so I hear what you're saying.

But in the context of the other bullet points, isn't it indicative of keeping a person in their home environment if possible until they're stable enough for a short-term crisis intervention?

MS. REYNOLDS: Objection. Sorry.

BY MR. DEEGAN:

Q. In order to keep -- in order to -- it means that they're not appropriate for residential level of care, a restrictive --

A. Sure. That's right. And you can make the argument that it all pivots around the word "inappropriate," and that by saying -- declare it inappropriate or unsuitable alternative to nonresidential care, you know, I reject that bullet point. But I think that it's out of left field as creating the impression of equivalence. Again, would that alone be enough to say that these don't comport with generally accepted standards of care, no, but it's awfully worrisome to me when we're looking for clinically appropriate matching for the habilitative or rehabilitative treatment and the reviewer is directed to consider whether just keeping them temporarily safe would be equivalent. I think that's rarely the case.

MS. REYNOLDS: And can I just lodge an objection to the last question. I just didn't get a chance. We're starting to talk over each other.